elcome

Department of Environmental Health

University of Cincinnati College of Medicine

"The mission of the Department of Environmental Health is to improve the quality of life by understanding the causes of environmental damage and identifying the effective methods of prevention."

Dr. Marshall Anderson, Director

This mission is accomplished through:

Research:
To obtain new scientific knowledge on the process by which environmental agents produce adverse human health effects.

Education:
To prepare tomorrow's professionals for leadership roles in research, education, service and patient care.

Service:
To diminish adverse health effects through interaction with governmental agencies and community groups.

Departmental Mission & Organization

University of Cincinnati Department of Environmental Health

EX. 131

Occupational & Environmental Medicine

The Division of Occupational and Environmental Medicine has three major foci. Number One: training physicians in the specialty of occupational medicine through the ACGME accredited Occupational Medicine Residency Training Program. Number Two: occupational epidemiology research of populations exposed to potential hazards within the workplace. Number Three: clinical evaluation of patients with potential occupational or environmental-related medical disorders. The Division of Occupational and Environmental medicine is multi-disciplined in character and extensively interacts with other divisions within the Department of Environmental Health as well as the Department of Physician Medicine and Rehabilitation, the Department of Internal Medicine, and the Department of Emergency Medicine. Extensive use is made of regional and national volunteer faculty who have expertise in the field of occupational health. The Occupational Medicine Residency Training Program is the oldest continuous post graduate program within the United States. On the average four residents graduate from the program on a yearly basis and go on to accept positions at other academic institutions, within industrial settings, or within local, state or federal agencies. Funding for the residency training program is through the National Institute for Occupational Safety and Health's Education and Research Center Training Grant as well as from the University Hospital and various private sources. Areas of ongoing research include pulmonary evaluation of workers exposed to refractory ceramic fibers (a type of man-made vitreous fiber), to absorbent gelling material, pesticides, herbicides, and fungicides, and reproductive effects of exposure to solvents and jet fuel. The pulmonary morbidity and mortality studies of workers involved with RCF manufacturing have identified an association between duration of employment in a refractory ceramic fiber manufacturing job and the occurrence of pleural plaques on chest radiographs. The Center for Occupational Health (COH) is a multi-discipline clinical center that provides occupational health services to the Cincinnati and Midwest communities. The COH is part of the Alliance occupational health organization, Health Alliance of Greater Cincinnati. Core faculty members from the Division administer as well as staff the Center's activities. The Center has four divisions: Occupational Health Clinic, Medical Surveillance Program, Occupational Pulmonary Services, and Industrial Rehabilitation Program. The Center for Occupational Health is recognized as a resource in the comprehensive field of occupational and environmental health for employers, employees, and health professionals in Cincinnati and the Midwest.

Faculty in the division of Occupational & Environmental Medicine hold 3 grants and contracts totaling about $447,118 in annual total costs.

James Lockey, MD, Professor, Director of Occupational and Environmental Medicine

Faculty and Research Interests

Dr. James Donovan, Assistant Professor

Dr. Donovan is Director of the Occupational and Environmental Medicine Residency Program. As an internist, occupational physician and industrial hygienist, Dr. Donovan is uniquely qualified to assess both health hazards and clinical outcomes in populations exposed to occupational and environmental toxicants. Dr. Donovan's research interests include both occupational and environmental clinical epidemiology studies.

Dr. Andrew Freeman, Assistant Professor

Dr. Freeman is Medical Director of the Occupational and Environmental Health Clinic, Center for Occupational Health. He has several research interests including biomonitoring for cyanide exposed populations, hypersensitivity pneumonitis, ergonomics, as well as other health outcomes in a variety of clinical occupational and environmental epidemiology

Ex. 132

Ex. 133

SSN	NAME (LAST, FIRST, MI)	EFF DATE	PERSONNEL ACTIONS	A126 REQ
0	Amadasu, Darlington	07/01/1999	01	

DATE: 7/16/99

VET STAT	TENURE ELIG	TENURE EFFECT DATE	HOME DEPARTMENT NO. & DESCRIPTION	HOME CAMP	FULL PART	PRIMARY JOB TITLE	RETIRE PLAN
A			13096 Environmental Health	2	F	Occupational Health Resident	Z

ANNUAL SALARY	BASE HRLY RATE	LONGV HRLY RATE	ADDL HRLY RATE
29,000.04			

UNIVERSITY OF CINCINNATI
NEW HIRE
PERSONNEL ACTION FORM

JOB	BEGIN DATE	END DATE	TK GR	POS NO	DEPT	SFT	JOB CL	JOB TYPE	JOB %	PAY RATE	PAY CYCLE	PAY TERM	CREDIT HOURS	SUPERVISOR'S NAME
	07/01/1999	06/30/2000		00000	13096		003093	R	100.00	2,416.67	M1	00	0.0	Dr. Donovan

FUND	ARE	ORG	FUNC	OBJ	SO	EC-CSO	ACCOUNT AMOUNT	EARN TYPE	START DATE	STOP DATE	ACCT %	WORK CITY
P021	040	E933	0114	1900	60	02	2,416.67	GTS	07/01/1999	06/30/2000	100.00	2211

JOB	BEGIN DATE	END DATE	TK GR	POS NO	DEPT	SFT	JOB CL	JOB TYPE	JOB %	PAY RATE	PAY CYCLE	PAY TERM	CREDIT HOURS	SUPERVISOR'S NAME

FUND	ARE	ORG	FUNC	OBJ	SO	EC-CSO	ACCOUNT AMOUNT	EARN TYPE	START DATE	STOP DATE	ACCT %	WORK CITY

ADDRESS - STREET	CITY	ST	ZIP	CHECK LOC	MAIL LOC	SEX	ETHNIC GR	BIRTHDATE	CITY OF RESID	SCHOOL DISTRICT NO.
6680 Wendee Drive #2303	Cincinnati	OH	45238	0056	0182	M	B		2211	1599

COMMENTS:
Attached: I-9, W4, IT-4. Pers Personal History Record has been sent to the benefits office.

VISA TYPE	EXP. DATE	CODE	COUNTRY OF RESIDENCE

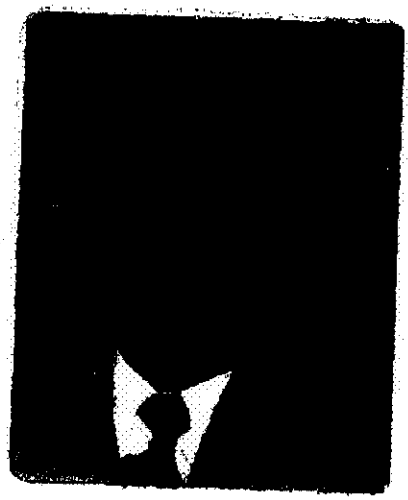
Kathy L. Crawford 2/22/99
DEPARTMENT HEAD DATE

/ /
DEAN/DIRECTOR/VICE PRESIDENT DATE

/ /
SPONS. PROG. ACCT. STUD. FIN. AID DATE

Dora Jefferson-Gaynor 8-5704
INDIVIDUAL COMPLETING FORM PHONE NUMBER

University of Cincinnati



DARLINGTON
AMADASU, MD, MPH
RESIDENT

ENVIRONMENTAL HEALTH

Ex. 133 (9)

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43266-0315 • (614) 466-3934 • Website: www.state.oh.us/med/

ACKNOWLEDGEMENT OF APPLICATION FOR TRAINING CERTIFICATE

July 19, 1999

Darlington Onobogie Amadasu MD
P.O. Box 670056
Cincinnati, Ohio 45267-0056

This is to notify you that your application for a training certificate was received by the Board on 7/19/99 in order to participate in the training program at University Hospitals of Cincinnati (OM).

Please be advised that you are hereby authorized to begin participation in the training program to which you have been appointed while your application is being processed. You are entitled to perform such acts as may be prescribed by or incidental to the internship, residency, or clinical fellowship program, but are not otherwise entitled to engage in the practice of medicine and surgery or osteopathic medicine and surgery in this state. You must limit your activities to the programs of the hospitals or facilities for which you have applied. You must train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program.

The processing time before issuance of a training certificate is ordinarily 6 to 8 weeks after receipt of an application by the Board. Applications are processed in the order received. An incomplete application or any unusual circumstances discovered during processing will result in deviation from this schedule. You will be notified if the application is incomplete or contains errors, or if there is difficulty in obtaining the independently requested recommendations.

The Ohio Administrative Code provides that the Board may abandon an application if you fail to complete the application process within six months of initial application filing. Submitted fees will not be refundable or transferable.

Sincerely,

Penny E. Grubb

Penny E. Grubb
Chief, Licensure

Ex. 134

EX. 135

AMADASU DAHLINYUN C 01 4/ /74
LAST NAME FIRST MIDDLE SOCIAL SECURITY NO. BIRTH DATE

2680 WENDEE DRIVE (#2303) CINCINNATI OH 45238
HOME ADDRESS CITY STATE ZIP CODE

✓ COLLEGE OF MEDICINE (M.D.) ___ COLLEGE OF LAW
GRADUATE DIVISION

___ ARTS AND SCIENCES ___ BUSINESS ADMINISTRATION
___ ENGINEERING ___ NURSING AND HEALTH
___ EDUCATION ___ DESIGN, ARCHITECTURE, ART AND PLANNING
___ SCHOOL OF SOCIAL WORK ___ PHARMACY
✓ COLLEGE OF MEDICINE ___ COLLEGE-CONSERVATORY OF MUSIC
___ CENTER FOR HEALTH RELATED PROGRAMS

PROGRAM MAJOR ___ SEX ___
QUARTER ADMITTED ___ MARITAL STATUS ___
DO YOU PLAN TO LIVE IN UNIVERSITY RESIDENCE HALL? ___ YES ✓ NO

UNIVERSITY OF CINCINNATI
SUPPLEMENTARY INFORMATION

COLLEGE OF MEDICINE ✓
COLLEGE OF LAW
GRADUATE DIVISION

This information must be returned to the appropriate college office. UNIVERSITY OF CINCINNATI. PLEASE PRINT. Use typewriter or ball point pen. BE CERTAIN ALL COPIES ARE LEGIBLE AND ALL INFORMATION IS PROVIDED.

Expected Graduation Year ___

SUPPLEMENTARY INFORMATION:
Years of consecutive residence in the State of Ohio prior to this date NONE
Home Address County ___
DO YOU EXPECT TO BE [X] FULL TIME [ ] PART TIME
Birthplace (City and State) BENIN CITY, NIGERIA
Home Telephone Number PENDING
DEGREE SOUGHT (OPEN)
IF MALE AND 18 YRS. OF AGE, ARE YOU REGISTERED WITH SELECTIVE SERVICE ___ YES ✓ NO IF YES, # ___

PARENT INFORMATION (OR LEGAL GUARDIAN IF OTHER THAN FATHER)
NAME PARENT DECEASED.
LAST FIRST MIDDLE
ADDRESS ___
NUMBER AND STREET CITY STATE ZIP CODE

HUSBAND OR WIFE (IF MARRIED)
NAME ___
ADDRESS ___
Years of consecutive residence in Ohio ___
EMPLOYER ___

The following information is requested in order that we may demonstrate to The U.S. Department of Health, Education and Welfare this institution's compliance with Title VI of the 1964 Civil Rights Act. Information is confidential. It will be available only for research and statistical purposes, and only upon specific authorization and for non-discriminatory use.
Please check the box that applies to you based upon your predominant ethnic background.

[ ] American Indian or Alaskan Native (1) [X] Black Non-Hispanic Origin (2) [ ] Asian or Pacific Islander (3) [ ] Hispanic (4) [ ] White — Non-Hispanic Origin (5) [ ] Non-resident Alien on Student or Temporary Visa (6) [ ] Other Specify (7) ___

HIGH SCHOOL FROM WHICH YOU WERE GRADUATED
NAME MADONNA CITY IHITTE-UMUAHIA STATE NIGERIA ZIP CODE ___ COUNTY ___ DATE 1965

COLLEGES ATTENDED
NAME UNIVERSITY OF LAGOS COLL-MED. ADDRESS LAGOS NIGERIA DATES ATTENDED 1975 — 1979
NAME UNIV. OF UTAH SCH. OF MED ADDRESS SALT LAKE CITY, UTAH DATES ATTENDED 1998 — 1999

COLLEGE DEGREE(S) EARNED BA, MS, MD, MPH (EXPECTED) WHERE LAST DEGREE WAS EARNED UNIV. UTAH. DATE 1999

CITIZENSHIP U.S. CITIZEN? YES [X] NO [ ] IF NO, GIVE TYPE VISA HELD ___ COUNTRY OF CITIZENSHIP ___

EMPLOYMENT RECORD
NAME OF FIRM U.C. & UIH: LOCATION (STATE) CINCINNATI TYPE OF WORK RESIDENT - MEDICAL STAFF DATES TODATE
NAME OF FIRM ___ LOCATION (STATE) ___ TYPE OF WORK ___ DATES ___

FINANCIAL SUPPORT [ ] Family [ ] Savings [ ] Loans [ ] Fellowships and Scholarships [ ] Assistantship [ ] Earnings [X] Other RESIDENCY PROGR.

Have you ever applied to U.C. before? [ ] Yes [X] No Which College? ___ When? ___
Will you attend U.C. Summer School prior to your regular enrollment? [X] Yes [ ] No
Have you ever attended U.C. before? [ ] Yes [X] No Which College? ___ When? ___
If above is yes, under what name? ___
LAST FIRST MIDDLE

(Optional) Do you have a handicap that may require special services or facilities? Yes ___
If yes is checked, you will receive additional information from the Office of Handicapped Student Services.

*Social Security Number is used as a student identification number at the University of Cincinnati.
If Social Security Number is not provided a unique identifying number will be assigned.

DATE ___ SIGNATURE ___

UC 201

DO NOT WRITE BELOW THIS LINE

BIRTH DATE MO-DA-YR	SEX	MARIT. STAT.	COLLEGE	ADMIT DATE YR.	ADMIT DATE QTR.	CAMP. COLL.	HIGHEST DEGREE	DEGREE OBJ.	EXP. GRAD. YR.	MAJOR	GRAD ADMIT	RE-ADMIT	CLASS

OFF CAMPUS COLL.	OFF CAMPUS QTR.	HIGH SCHOOL CODE	HS. GRAD. YR.	HEALTH CODE	G.S. CODE	HOME ADDRESS CODE STATE	HOME ADDRESS CODE CITY	HOME ADDRESS CODE ZIP	RES.

STUDENT RECORDS OFFICE

EX. 135

UNIVERSITY OF CINCINNATI
AUTHORIZATION AGREEMENT FOR
PAYROLL DIRECT DEPOSIT

I hereby authorize the University of Cincinnati to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits, to my account(s) indicated below, and to the financial institution(s) named below to credit and/or debit the same to such account(s).

Please attach a copy of voided check(s) or deposit voucher(s), so that we can verify the routing and account information.

OPTION #1: NET PAY

Circle one: Add Delete **Circle one: Checking Savings**

BANK OR FINANCIAL INSTITUTION CINCO FEDERAL CREDIT UNION

CITY, STATE CINTI, OHIO

ROUTING/TRANSIT NUMBER 242076 ACCOUNT NUMBER

By selecting this option, you are indicating that your net pay should be deposited to this institution.

OPTION #2: ONE AMOUNT DEDUCTION

Circle one: Add Delete Change (amount only) **Circle one: Checking Savings**

BANK OR FINANCIAL INSTITUTION

CITY, STATE

ROUTING/TRANSIT NUMBER ACCOUNT NUMBER

PLEASE INDICATE AMOUNT: 0.00

OPTION #3: FIXED AMOUNT DEDUCTION

Circle one: Add Delete Change (amount only) **Circle one: Checking Savings**

BANK OR FINANCIAL INSTITUTION

CITY, STATE

ROUTING/TRANSIT NUMBER ACCOUNT NUMBER

PLEASE INDICATE AMOUNT: 19.00

This authority shall remain in full force and effect until the University has received written notification from me of its termination in such time and in such manner as to afford the University and financial institution(s) a reasonable opportunity to act upon it. Receipt in Payroll & Employee Information Services, mail location #0001, of such notification seven (7) days prior to a pay date will ensure timely processing. The University reserves the right to terminate this agreement without prior notification.

NAME DARLINGTON AMADASU SOC SEC # [redacted]

SIGNATURE [signature] DATE 10/26/05

Please allow three to four weeks for implementation

A 25 5/97

EMPLOYEE

Ex. 136

University of Cincinnati

Benefits
Division of Student Affairs/Human Resources
University of Cincinnati
PO Box 210099
Cincinnati OH 45221-0099

Phone (513) 556-6381
Fax (513) 556-4501

DATE: August 2, 1999

TO: Darlington Amadsu
2680 Werdee Dr., #2303
Cincinnati, OH 45238

FROM: Adam W. Benedict
Benefits Counselor
Benefits Office
ML #0099

RE: **CHOICE BENEFITS ENROLLMENT**

As a result of your new appointment as an Occupational Health Resident, enclosed you will find a personalized Choice Benefits Enrollment form for 1998.

Please complete the enrollment form (front and back) and return it to Mail Location #0099 by August 16, 1999 the date indicated on the bottom of the form.

If the enrollment form is not returned to the Benefits Office by the deadline, you will automatically be defaulted to the following benefits:

- No Coverage

You will not be able to make changes in your benefits until annual enrollment each Fall, unless you have a change in family status. The following family status changes would allow you to request certain benefit changes before the next enrollment period:

- birth or adoption of a child
- death of a covered dependent
- marriage or divorce
- a change in your or your spouse's employment that affects benefits (not including annual enrollment) or
- loss of dependent eligibility

For any benefit changes that take effect due to a change in family status, a completed confirmation form must be received by the Benefits Office within 31 days of the family status changes. If you miss the 31-day deadline, you must wait until the next enrollment period.

Also, included in this packet is information on the PERS Retirement System and the new Alternative Retirement Plan. You must make an election for one of these retirement plans no later than **September 28, 1999.** After this date, your retirement plan will default to the PERS Retirement System.

If you have any questions, and/or want to make an appointment regarding your benefits, please feel free to contact me at 513-556-0377.

Ex. 137

[redacted]

NAME: AMADIS K | LAST: | FIRST: DARLINGTON | MI: O | MAIDEN:

SS#: [redacted] | TODAY'S DATE: 08 / 16 / 99 (Mo. Day Yr.)

Employee Orientation Reference Data Report

Please complete the following items by either filling in the blocks or placing a check (✓) mark where applicable. Should a particular item not apply to you, indicate as such by placing a N/A in the appropriate blank.

ADDRESS 2650 WELDER DRIVE #2103 (Street) CINTI (City) OH (State) 45238 (Zip)

Have you had a pre-employment physical? ☐Yes ☒No If not, when is your physical scheduled? FEB 2000

JOB TITLE MEDICAL RESIDENT DEPARTMENT OCC. MED. & ENVIRONMENTAL MED.

STARTING DATE IN CURRENT POSITION 01/07/99 CAMPUS MAIL LOCATION 522

HOME PHONE NUMBER 521-661-2547 CAMPUS PHONE NUMBER 536-0526

UNIT: ☐Clifton Campus ☐Medical Center ☐University Hospital ☒Holmes Hospital
☐Raymond Walters ☐Clermont ☐OMI/CCAS

RECEIVED AUG 16 1999 BENEFITS DIVISION

STATUS Please check (✓) the one block in each column which describes your employment status:

☒Full-Time	☐Permanent	☐New Hire	☐Classified
☐Part-Time	☐Temporary	☐Reinstated	☐Unclassified
☐Seasonal	☐Provisional	☐Re-Hire	☐Exempt
☐Intermittant		☐Promotion	☐Faculty

SEX: ☒Male ☐Female MARITAL STATUS: ☐Single ☒Married DATE OF BIRTH 01/01/45 AGE 53

SPOUSE NAME [redacted] Date of Birth [redacted]

Is your spouse employed? ☐Yes ☒No If yes ☐Full-time ☐Part-time

Name and address of employer UNIV. CINCINNATI

CHILDREN
Please list the name, sex, age, and date of birth of each of your children who are unmarried and who are dependent upon you for financial support.

NAME: [redacted] SEX: [redacted] AGE: 19 DOB: [redacted]

RETIREMENT
Do you currently have an existing retirement account with any of the following Ohio Retirement Systems?

☐Yes	☒No	Public Employees Retirement System (PERS)	☐Yes	☒No	School Employees Retirement System (SERS)
☐Yes	☒No	State Teachers Retirement System (STRS)	☐Yes	☒No	Highway Patrol Retirement System
☐Yes	☒No	City of Cincinnati	☐Yes	☒No	Other NONE

OHIO SERVICE
Please indicate on the reverse side of this form whether or not you have had previous employment with the University of Cincinnati, University Hospital, the State of Ohio or any of its political subdivisions.

CERTIFICATION
I certify that the above listed information is correct and understand that falsification of information will be cause for termination of my employment.

Signed [redacted]

EX 139

Ex. 1387

EX. 139

PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO
277 East Town Street Columbus, Ohio 43215-4642

AUG 16 1999
BENEFITS DIVISION

PERSONAL HISTORY RECORD

All sections of this Form must be completed in full including the certification by your payroll officer and the affidavit. All statements are to be made under oath and may require substantiating proof. Proof of date of birth will be required to obtain retirement and other benefits. Be accurate when entering your Social Security number; copy it from your card. All signatures must be in ink; other entries may be typewritten or printed clearly. A refund of accumulated contributions, retirement allowances, disability benefits, or survivor benefits may only be paid if this Form is properly completed.

SECTION I PERSONAL INFORMATION

Full Name: AMADASU (Last) DARLINGTON (First) O. (Middle)

Home Address: 7650 WENDEE DRIVE; #2307 (Street) CINTI (City) OH (State) 45239 (Zip)

Social Security Number:

Sex: M Date of Birth: 01/01/45 (Month/Date/Year) Place of Birth: BENUE STATE, NIGERIA (Town and State or Foreign Country) Marital Status: ☐ Single ☑ Married ☐ Widowed ☐ Divorced ☐ Separated

DO NOT WRITE IN THE FOLLOWING SPACES FOR PERS OFFICE USE ONLY

Previous PERS Number

Employer Code

Received for Record Date Stamp

Please list your family members and their dates of birth below. Include full names of each parent even if deceased; list only natural or adopting parent(s).

	NAME	DATE OF BIRTH Month	Date	Year
Spouse				
Children				
	5 UNIS			
Father	A AMADASU			
Mother	DEC.			

SECTION II SERVICE INFORMATION

1. Give date of first service as an employee in any public employment in Ohio ✓

2. Have you been a member of any of the following retirement systems?

a) Ohio Police & Firemen's Disability and Pension Fund (PFDPF) ☐ yes ☑ no
b) Cincinnati Retirement System (CRS) ☐ yes ☑ no
c) State Highway Patrol Retirement (HPRS) ☐ yes ☑ no
d) School Employees Retirement System (SERS) ☐ yes ☑ no
e) State Teachers Retirement System (STRS) ☐ yes ☑ no

If you answered "yes" to any of the above, provide the following information for each system marked:

Membership date(s) from _____ to _____ System(s) _____
Retired? ☐ yes ☐ no Date(s) _____ System(s) _____
Refunded Account? ☐ yes ☐ no Date(s) _____ System(s) _____

3. Are you presently or have you been receiving disability retirement benefits from any state or municipal retirement system in Ohio? ☐ yes ☑ no
If "yes", which system? _____

Please turn page

EX. 139

SECTION III EMPLOYMENT INFORMATION

1. State present title, employer, and department in which employed:

TITLE	EMPLOYER	DEPARTMENT, OFFICE, BOARD, COMMISSION, OR INSTITUTION
RESIDENT	U.C./U.C.H.	OCCUPATIONAL & ENVIRONMENTAL MEDICINE

2. State date present employment began (specify month/date/year): 07/01/95

Was this service ever covered by approved exemption? ☐ yes ☒ no

If "yes", attach copy of approved Request for Optional Exemption (F-3) and give dates the limitations were exceeded _____

3. Is current service an elected position? ☐ yes ☒ no

If "yes", term began _____. Submit Application for Membership from an Elective Official (A-9) in duplicate.

4. Have you ever held another elected position? ☐ yes ☒ no

If "yes", state office held _____ and dates _____

SECTION IV BENEFICIARY DESIGNATION

In addition to benefits available to you, benefits may be available to your qualifying beneficiary(ies) upon your death. Your beneficiary is determined in one of two ways: **automatic succession** as established by law or **specific designation** which requires you to name a person, persons, trust, estate, or an institution. By law there are certain events which cancel a specific designation: marriage, divorce, dissolution of marriage, legal separation, the birth or adoption of a child, or withdrawal of account. If you do not submit a new designation to PERS after one of these events occurs, your beneficiary will be determined by automatic succession.

•**If you are not retired from another state retirement system** and a specific designation is not filed, at your death any amount due is payable to your first qualifying beneficiary in the following order: **(1)** spouse, **(2)** child(ren), **(3)** parent(s), or **(4)** estate. If you are satisfied with this order, you do not need to do anything. If you would like to make a **specific designation**, please mark this box ☐; information and the proper form will be sent to you. If you have made a previous designation and your account is still on deposit with PERS and you want to keep that previous designation, please mark this box ☐.

•**If you are retired from another state retirement system** and a specific designation is not filed, at your death any amount due is payable to your first qualifying beneficiary in the following order under automatic succession: **(1)** spouse; **(2)** child(ren) share equally; **(3)** parents share equally; or **(4)** estate. If you are satisfied with automatic succession, you do not need to do anything. If you would like to make a **specific designation**, please mark this box ☐, and information, along with the proper form, will be sent to you.

SECTION V EMPLOYEE AFFIDAVIT

State of Ohio, County of Hamilton

Being duly sworn, the undersigned states that the statements contained in this form are complete and true to the best of his/her knowledge and belief.

_____
Signature of Member

Sworn to and subscribed to me this _____ day of _____, 19____

_____
Notary Public

SECTION VI PAYROLL OFFICER'S CERTIFICATION

1. State present rate of compensation: _____ per hour / day / month
Circle one

2. Explain certified allowances paid for full maintenance (consisting of housing, laundry, and meals) _____

I hereby certify that _____ began service with
Employee's Name

_____ on _____, and the statements set
Employing Unit Date

forth in Sections I, III, and VI are true and accurate as disclosed by the records of this department.

Ex. 140

Signed _____ Employing Unit _____

Title _____ Department _____

Ex. 140